STATUS REPORT ON VIRGINIA'S MEDICAID PREFERRED DRUG LIST (PDL) PROGRAM

Joint Commission on Health Care Behavioral Health Subcommittee

Patrick W. Finnerty, Director
Virginia Department of Medical Assistance Services

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Activities of the Pharmacy & Therapeutics (P&T) Committee

Meeting Date	Therapeutic Classes Reviewed	P&T Committee Decisions Made
June 18th	None-organizational meeting only	None
June 30th	• Proton Pump Inhibitors (PPI): Reduce Stomach Acid, Ulcers, Gastroesophageal Reflux Disease • Histamine Type - 2 Receptor Antagonists (H2RA): Reduce Stomach Acid, Ulcers, Gastroesophageal Reflux Disease • Antihistamines: Allergies, Head Colds With Head Congestion, Itching • Nasal Steroids: Allergic Rhinitis	All four classes were appropriate for inclusion in a PDL program. All drugs in these classes were considered clinically effective
August 12th	• Selective COX-2 NSAID Inhibitors: Inflammation, Arthritis, Pain • HMG-CoA Reductase Inhibitors: Reduce Cholesterol Levels • Sedative Hypnotics: Sleep • Beta Adrenergics: Asthma • Inhaled Corticosteroids: Asthma	All five classes were appropriate for inclusion in a PDL program. All drugs in these classes were considered clinically effective
September 3rd	• Angiotensin Converting Enzyme Inhibitors (ACEI) • Angiotensin II Receptor Antagonists (ARB) • Calcium Channel Blockers • Beta Adrenegic Blocking Agents (Beta Blockers)	All four classes were appropriate for inclusion in a PDL program. All drugs in these classes were considered clinically effective.
October 15th	• No classes will be reviewed	Committee will make initial recommendations on the "preferred" and "non-preferred" drugs for the above 13 classes of drugs to be implemented in January 2004.
November 11th	• Will review additional classes of drugs to be added to the PDL program in April 2004.	Committee will also: • Make final recommendations on the 13 classes of drugs to be implemented in January 2004 • Review clinical criteria for prior authorization process for the 13 classes

PDL Implementation Advisory Committee

- The PDL Implementation Advisory Committee met on September 11, 2003. The Committee reviewed:
    - Status of the PDL program
    - Draft of the prior authorization process for "non-preferred" drugs
    - Information on provider/consumer education

- Next meeting is scheduled for October 20, 2003. The Committee will review
    - Status of the PDL program
    - Status of the Prior Authorization Process
    - Status of PDL Provider and Consumer Education
    - Pharmacy Threshold Program (More than nine drugs)
- A list of the Committee members is attached on page 6

First Health Activities

- Call center available in November 2003
- System changes to the MMIS are on schedule
- Mailings to the providers and beneficiaries in November

Supplemental Rebate Contracting Process

- Deadline for pharmaceutical manufacturers to submit supplemental rebate bids was October 3, 2003
- Bids were received from nearly all manufacturers with drugs in the first 13 classes of drugs to be implemented in January, 2004
- First Health is analyzing bids and preparing information for review by the Pharmacy & Therapeutics Committee.

RESPONSE TO CONCERNS REGARDING MICHIGAN'S IMPLEMENTATION OF A PREFERRED DRUG LIST PROGRAM

The following italicized text represents the 10 significant concerns of the Michigan PDL program as identified by Mark Reinstein of the Mental Health Association in Michigan. Below each concern are steps being taken by Virginia to address the issue.

1. *Failure to provide beneficiaries adequate notice*

   - Provider/consumer education program is being developed with assistance from the PDL Implementation Advisory Committee.
   - Information about the PDL program will be distributed to all affected Medicaid clients 45 days in advance
   - Members of the PDL Implementation Advisory Committee will assist in communications to Medicaid clients and providers
   - "Soft edits" will be in place in advance of the PDL implementation in January.

2. *Forced drug-switching (example related to serious mental illness)*

   - Anti-psychotics are not subject to Virginia's PDL
   - Clinical criteria for prior authorization will be established by the P&T Committee

3. *Implementation of a "fail first" standard and lack of opportunity for prescribers to declare medical necessity*

   - Clinical criteria for prior authorization have not been established yet; P&T Committee will establish the criteria
   - Prescribers will be advised of prior authorization criteria

4. *Creation of financial incentives for pharmacy benefit manager denials*

   - First Health (PDL Contractor) is paid a flat fee for administering the PDL program; no "per case" fee for various types of contacts or reviews is paid
   - There are no incentives in the contract to deny prior authorization requests
   - Item 325 VVV of the 2003 Appropriations Act prohibits any contract from including any inducement, bonus, or other financial incentive to deny or administratively delay medically appropriate prescription drug therapy

5. *Lack of protection for mental health drugs*

   - Anti-psychotics and anit-convulsants are not subject to PDL
   - Antidepressants are not among the first 13 classes of drugs to be included in the PDL

- Two psychiatrists are on the P&T Committee; a Board-Certified Psychiatric Pharmacist will work with the Committee when reviewing mental health drugs

6. *Absence of uniformity among different pharmacy benefit managers*

- Virginia Medicaid HMOs administer their own preferred drug lists and criteria; DMAS will work with the HMOs to standardize procedures as much as possible. For example, DMAS has modeled the Prior Authorization (PA) form after the one utilized by the largest HMO PA form.
- DMAS is consulting with the PDL Implementation Advisory Committee to make the prior authorization process understandable and easy to navigate

7. *Inappropriate clinical intrusion by pharmacy benefits managers*

- The PDL contractor (First Health) will administer the PDL program as directed by the P&T Committee and DMAS; the P&T Committee will decide the criteria.
- The PDL Implementation Advisory Committee will advise DMAS of any concerns that may need to be addressed

8. *Ineffective communication with pharmacists (description of problem related to the "preferred" and "non-preferred" list changing constantly and "grandfathering" process not working)*

- Michigan implemented 41 classes of drugs in one month; Virginia will implement 13 classes initially; several additional classes will be added a few months later.
- "Soft edits" will be implemented prior to full implementation of the PDL to help inform pharmacists/clients of the "preferred" drugs.
- Providers and pharmacists will receive education materials on a scheduled basis prior to the implementation and a month later.

9. *Insufficient empowerment of the Pharmacy & Therapeutics Committee (no consumer member of committee; half of the Committee are Michigan Dept. of Community Health staff)*

- In contrast to other states, the P&T committee is the driver of this program, not the vendor. All clinical decisions will be made by the P&T Committee.
- Virginia has a stellar P&T Committee, chaired by Dr. Randy Axelrod
- Membership is based largely on recommendations of various provider associations
- Membership of the Committee (between 8-12 members and 2 physicians for every pharmacist) is set forth in the Appropriations Act
    - There are no DMAS staff on the Committee

- Two psychiatrists and a consulting Board-Certified Psychiatric Pharmacist will make recommendations on all mental health drugs

10. Lack of substantive program reporting

- Item 325 ZZ.5 of the 2003 Appropriations Act required DMAS to report on the design of the program to the General Assembly not later than 10 days from enactment of the Act; while not required, DMAS is submitting ongoing status reports to the General Assembly
- DMAS must document any decisions which deviate from the recommendations of the P&T Committee
- Item 322.J of the 2003 Appropriations Act requires DMAS to submit an annual report to the General Assembly on impact of all prior authorization requirements.
- DMAS will be conducting an evaluation of the PDL program. Accordingly, the program is being designed in consideration of these evaluation needs.
- DMAS has created a website (**www.dmas.state.va.us**) which provides all documents related to the PDL program. In addition, any comments on the program can be submitted to **pdlinput@dmas.state.va.us**.

PDL Implementation Advisory Committee

Members

Cindi Jones, Chair, Virginia Department of Medical Assistance Services

Matthew Sheffield, Boehringer-Ingelheim

Madeline Abbitt, Generic Manufacturers Association

Anne Leigh Kerr, PhRMA

Mike Jurgensen, Medical Society of Virginia

Becky Snead, Virginia Pharmacy Congress

J. E. (Hill) Hopper, R. Ph., for the Virginia Health Care Association

Valeria D. Thomas, for the Virginia Health Care Association

Jill Hanken, Virginia Poverty Law Center

John Pezzoli, Virginia Association of Community Services Boards

Susan Umidi, Virginia League of Social Services Executives

Dr. J. Evans, Department of Mental Health, Mental Retardation and Substance Abuse Services

Sheryl Garland, for the Virginia Hospital & Healthcare Association

David Markowitz, Psychiatric Society of Virginia